Appendix P

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Access to Recovery (AR ATR)

ATR Care Coordinator Name: _____

Referring Agency: _____ **Referring Agency Contact:** _____

Address: _____

Fax: (_____) _____-_____ **Phone:** (_____) _____-_____

Email: _____

Participant Information: **Gender:** ____ **Male** ____ **Female** **Pregnant?** ____**Yes** ____**No**

Participant Name: _____ **Birth Date:** _____/_____/____

Address: _____ **City:** _____

County_____ **Zip:** _____

Primary Phone: (___ ____) _____-_____**TYPE:** ____**Home** ____**Work** ____**Cell** ___**Other**

Secondary Phone: (___ ____) _____-_____**TYPE:** ____**Home** ____**Work** ____**Cell** ___**Other**

Language Preference (check one): _____ **English** _____ **Spanish** _____**Other -** _____

Eligibility Category *(all fields are required)*:

☐ Client States Income is Under 200% of Poverty
☐ Desires Assessment for Arkansas ATR Program Eligibility
☐ 18 or older

Eligible Population (*check all that apply*)

- ☐ Member of Arkansas National Guard, Member of Military or veteran
- ☐ Family involvement **or** at risk of family involvement with the DHS Divisions of Children and Family Services (DCFS) or Youth Services (DYS)
- ☐ Adult convicted of Driving While Under the Influence (DUI) or Driving While Intoxicated (DWI) offenses

OPTIONAL

☐ Referring Agency would like confirmation of ATR enrollment
This will require ATR Care Coordinator to obtain client consent.

Appendix B

Arkansas Access to Recovery - Eligibility Form

Date of Session: Client Name:

Client DOB: Client ID:

Client Address:

Client Phones:

Care Coordination Provider:

Section I - The client is eligible for ATR services if questions 1 through 6 are answered Yes and the Care Coordinator has obtained the required documentation that the individual meets the <200% federal poverty guidelines.

Recovery Support Services Eligibility

1. The client is 18 years of age or older. ____YES ____NO

2. The client has a positive screening for a substance use disorder ____YES ____NO

The client is a resident of Benton, Craighead, Crawford, Faulkner, Garland, Independence, Jefferson, Lonoke, Pulaski, Saline, Sebastian, Washington, or White County ____YES ____NO

3. Member of one of the following populations:

- Arkansas National Guard, Members of the Military or Veterans
- Pregnant Women
- Family involvement or at risk of family involvement with the DHS Divisions of Children and Family Services (DCFS) or Youth Services (DYS)

- Convicted of Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) offenses 4. The client demonstrates the need for ATR covered services. ____YES ____ NO

5. The client is at or below 200% of the current Federal Poverty Level Guidelines. Please refer to the current Federal Poverty Level Guidelines at http://aspe.hhs.gov/poverty. ____YES ____NO

6. The client does not have insurance or personal financial resources to pay for requested ATR covered services documented in Section II. ____YES ____ NO

Substance Use Disorder Treatment (must answer Yes to questions 1 - 6 and 7)

7. The client has documented assessment of SUD treatment need at this time and requests services.
____ YES ____NO

Section II - Document client needs and requests for specific ATR covered services.
Document lack of insurance or other financial resources for requested ATR covered services

All ATR clients receive the following covered services:
☐ ATR Assessment with GPRA Intake Interview (1 session)
☐ ATR Care Coordination (up to 10 units per six months)
☐ ATR Care Coordination with GPRA Discharge Interview (1 session)
☐ ATR Care Coordination with GPRA Follow-up Interview (1 session)

Substance Use Treatment Services

Brief Intervention:

Assessment:

Treatment Planning:

Pharmacological Interventions:

Individual Counseling:

Group Counseling:

Individual Relapse Prevention Services:

Group Relapse Prevention Services:

Alcohol/Drug Testing:

Family/Couples Education Group:

Family/Marriage Group Counseling:

Multi-person (family) Education (Individual Family):

Family/Marriage Counseling (Martial/Family Counseling):

Recovery Check-Up:

Continuing Care Counseling:

Residential Treatment:

Recovery Support Services

Other Educational Services Group:

Employment Readiness/Training Services:

Housing Support Services:

Educational and Remediation Services:

Parenting/Child Development Education Services:

Financial Management/Credit Counseling:

Life Skills:

Medical/Dental Screening:

Medical/Dental Services:

Psychiatric Evaluation:

Psychological Testing:

Mental Health Therapy Services:

Health Care Education-Group:

Child Care:

Supportive, Transitional, Drug-Free Housing:

Sober Recreational/Fitness Activities:

Transportation Services:

Peer Coaching or Mentoring:

Spiritual Support:

Supplemental Needs:

Clothing/Hygiene Products:

Education:

Psychotropic Medication:

Utility Assistance:

Wellness:

Restorative Dental Care:

Co-Pays:

Other Needs:

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if applicable)

Provider/Witness Signature: _____ Date: _____

PROVIDER CONTRACT REQUIREMENTS

Care Coordinators

Every client must be offered choice of care coordinators and choice of providers. Once client has chosen the care coordinator, the coordinator will meet with the client within 48 hours to:

1. **Conduct Intake Interview (must be confidential and one-on-one, not in a group setting:**
   - Determine eligibility based on the following criteria (client must meet all three eligibility requirements and documentation must be in the client's individual case record):
     - ✓ Income-200% of poverty level*

Household Size	Gross Monthly Family Income
1	$1,815.00
2	$2,451.66
3	$3,088.33
4	$3,725.00
5	$4,361.66
6	$4,998.33
7	$5,635.00
8	$6,721.66
9	$7,358.32
10	$7,415.01
For each additional family member add	$636.66

**families who receive TEA, Medicaid, SSI, AR Kids First, or Food Stamps will automatically qualify as their income would be below 200% of poverty*

     - ✓ Residence in one of the 13 counties
     - ✓ Categorical eligibility
       - Multiple DUI/DWI offenses with continuing substance use disorder (SUD) if DUI/DWI offenses are not recent
       - Pregnant women with SUD
       - Military (Army Reserve/National Guard/Activity Duty)
       - Adults in families with (or at risk of) involvement with AR DHS child welfare Divisions of Children & Family Services (DCFS) or Youth Services (DYS)—e.g., active DCFS supportive or protective services case; or meets the DYS criteria for preventive services, or has a FINS petition, or adjudication as a juvenile delinquent, or child is currently in the custody of DYS and will be released on aftercare status.
   - Issue Voucher for Care Coordination Services
   - Complete GPRA, Arkansas questions, and RSS, and client confidentiality disclosure form and enter information into AR WITS (cannot bill for an intake until all steps have been completed)
   - Develop Recovery Support Plan
   - Client determines services to be provided under ATR
   - Care Coordinator offers choice of service providers
   - Contact service provider to determine what funding source will be used and ability to accept client
   - If ATR funds will be used, issue voucher(s) based on client's selection of service providers
   - Purchase $15 gift card to be used at 6-month follow-up

Conduct monthly contacts and enter encounter information in AR WITS

Issue/re-issue vouchers based on monthly contact and determination of continuing service needs

Complete GPRA 6-month follow-up and issue gift card to client (client must sign receipt)

Discharge client in AR WITS based on completion of recovery support plan goals/objectives or exhausting ATR funding.

If client requests change is service provider, cancel current voucher and issue voucher for new provider.

If client requests change in care coordinator, client must be referred to the Recovery Support Services Coordinator who will transition client. Care coordinator must turn over copies of the complete client record and attend transition conference with the client and the new care coordinator.

Maintain complete client files for review by DBHS or its representatives.

SERVICE/RECOVERY SUPPORT SERVICES PROVIDERS

Accept Vouchers for services

Provide services in accordance with the vouchered services

Document all service encounters in the WITS system

Maintain client confidentiality

Notify Care Coordinator if client leaves service or is re-locating to another county

Section V: ATR Provider Responsibilities and Assurances

A. The Provider agrees to comply with all the requirements set forth in this Agreement. Failure to comply is grounds for termination of participation in the Arkansas ATR Project and for possible further action by DHS.

B. The Provider agrees that any services provided prior to the effective date of this Agreement are the sole responsibility of the provider and in no way establishes DHS liability for payment of services rendered prior to the effective date of this Agreement.

C. The Provider agrees **to attend DHS-sponsored mandatory training concerning this Agreement** and to comply with all the requirements set forth in this Agreement. Failure to comply is grounds for termination of participation in the Arkansas ATR Program and for possible further action by DHS.

New Care Coordinators must complete all of the required training (as specified in Attachment O of the ATR Provider Manual) **prior to initiation of service delivery**. In lieu of DBHS provided training, New Care Coordinators may submit documentation of prior training in Ethics/Confidentiality and Motivational Interviewing. Documentation of at least 6 months experience in working with individuals with SUD prior to the date of this agreement may be provided in lieu of Recovery Support Services and Addiction and Recovery Training.

All New Direct Service Providers must complete AR ATR VMS/Reporting/Billing/Waste, Fraud & Abuse/ and Basic Confidentiality training **prior to the initiation of service delivery**. The remaining mandatory training (as specified in Attachment O of the ATR Provider Manual) must be completed **within sixty (60) days of signing the Agreement**.

D. The Provider agrees to maintain certification to provide ATR services and to comply with all certification standards. This Agreement terminates upon any final agency determination of adverse action against the Provider's certification. The termination of the Agreement because of adverse certification action is effective immediately upon the action being taken, and remains effective notwithstanding any appeal of the adverse action. If a Provider's compliance with certification or certification rules cannot be determined because the Provider does not submit required information or does not permit reasonable access to the Provider and its records, this Agreement will be terminated upon written notification to the Provider.

E. The Provider agrees to accept the ATR Voucher as authorization to provide and bill for services. The Provider agrees to accept reimbursement received from DHS as full and final payment for all services covered by this Agreement the collection of fees expressly authorized by DHS.

F. The Provider agrees not to accept clients without Voucher obligating DHS.

G. The Provider agrees that DHS will not pay Providers for ATR services retroactive to the date of the Voucher.

H. The Provider must submit a bill for actual services performed to receive payment, utilizing the VMS System.

I. The Provider agrees to submit billing within five (5) days of the date the service was actually delivered to the eligible client. No exceptions will be allowed.

J. The Provider agrees that only the authorized representative will submit bills to DHS, as specified in the Electronic Signature Verification Form. The Provider agrees to submit a new Electronic Signature Verification Form within ten (10) working days of any change in the authorized representative. The Provider accepts liability for all bills submitted to DHS using the VMS. Each Provider authorized representative will be issued a Password and other authentication for the VMS System.

K. Voucher Agreements and ATR Certification are non-transferable. A change in Taxpayer Identification Number (TIN) will require new Voucher Agreement and ATR Certification. The Provider agrees to notify DBHS of any change in ownership or TIN within ten (10) working days of the change. The Provider agrees that clients receiving substantially the same services shall not be charged at a rate less than that paid for by clients under this Agreement.

L. The Provider agrees to notify the ATR Case Coordination Services Provider when a client withdraws from the ATR Program. Notice, in the form of fax, telephone or electronic mail shall be provided no later than the next working day after the client withdraws. The Care Coordination Service Provider will terminate the Voucher in the VMS system.

M. The Provider understands that DHS will issue authorizations which are valid only for units of service the clients are eligible to receive assistance as determined by DHS.

N. The Provider agrees to promptly correct all billing or payment errors. In addition to any other remedy, which may exist in law, equity, or administrative procedures. DHS may, after proper notification, effect correction through adjustments in current and subsequent payments to the Provider and/or other measures as necessary. Payments may be withheld until verification of service delivery. Service documentation must be presented upon request by DHS staff or authorized representatives within one (1) hour of the request. All other records pertaining to delivery of services under this Agreement (including financial records) must be made available by 10:00 A.M. the day following the request from DHS staff or authorized representative. Site visits by DHS staff or authorized representatives may be unannounced.

O. The Provider agrees to retain all books, records, and other documents relating to expenditures, services rendered, or individuals served under this Agreement for five (5) years from the date this Agreement expires. If an audit or investigation is pending at the end of the five year period, information shall be retained until resolution of the audit, investigation. Any person authorized by DHS will have full access to these materials during this period.

P. The Provider agrees to document and maintain service delivery records for a period of six (6) years. Documentation shall include the client's name, identification number, date and time of service, summary of the encounter, and signature of the person providing the service. Documentation must reconcile with billing records. If service documentation is not available, DHS will consider the payment in question to be an overpayment.

Q. The Provider will maintain all client records in a confidential manner. Upon request, access to Provider records will be made available to DHS employees, DHS designated agents, or any agency of state or federal government for purposes of auditing or any other reason connected with DHS service programs. When needed to verify the Provider's cost allocation of non-duplication of payment, the Provider will make statistical records on expenditures charged to other funding sources available. The Provider may require official identification prior to allowing records access. This restriction does not apply to disclosures made with the informed, written consent of the client. If the client has been declared incompetent by a probate court, the client's guardian may consent on the client's behalf.

R. The Provider agrees to have an annual audit in accordance with the "Guidelines for Financial and Compliance Audits of Programs Funded by DHS" effective for the period of this Agreement. A copy of the "Guidelines" will be provided upon request. An audit is required:

   a. Failure to submit an audit will result in the Provider losing the privilege to participate in the ATR Program until the issue is resolved, and may result in the Provider's exclusion from all DHS programs per DHS Policy 1088. (Notice will be provided in writing with specific timeframes for submission of the audit.)
   b. Submission of falsified records or participation in any form of fraud by a Provider will result in exclusion from all DHS programs.
   c. Whether an audit is required or not, all financial information will be made readily available for any review conducted by a DHS authorized representative.

S. The Provider agrees not to discriminate against any employee or applicant for employment. Upon a final determination by a court or administrative body having proper jurisdiction that the Provider has violated state or federal laws and regulations regarding discrimination, DHS may impose a range of appropriate remedies, up to and including termination of the Agreement and exclusion from all DHs programs.

   The Provider agrees to comply with Titles VI and FVII of the Civil Rights Act and to operate, manage and deliver services without regard to age, religion, disability, political affiliation, veteran status, sex, race, color or national origin.

T. The Provider agrees to comply with Executive Order 98-04 (Guidelines for Employment, Grants, Contracts, and Purchasing) by completing and returning the appropriate Disclosure Forms to the Department. Failure to make any disclosure required by Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this Agreement. Any Provider, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the DHS.

U. The Provider agrees to comply with Public Law 101-121 (Anti-Lobbying Act):
   a. If the Provider receives more than $100,000 per award of appropriated federal funds in any Agreement period (July 1 – June 30), the Provider must certify that these funds will not be used to pay for lobbying activities, by completing a Certification Regarding Lobbying Form (DHS-9350) and submitting the form to the Department.
   b. If the Provider has paid or will pay for lobbying using funds other than appropriated federal funds, Standard Form LLL (Disclosure of Lobbying Activities) must be competed and submitted to the Department.

   The Provider (referred to as the lower tier participation in the following clause) agrees to comply with Executive Order 12549 (Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary7 Exclusion – Lower Tier Covered Transactions), which states:

   By signing and submitting this lower tier proposal (this Agreement), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

   1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
   2. Where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal.:

V. The Provider agrees that it will indemnify and hold harmless DHS against any and all liability, loss, damages, costs or expenses which DHS may sustain, incur or be required to pay as a result of any act or omission of the Provider.

W. The Provider agrees to notify DHS immediately of any change in ownership, change in business structure, facility site location, change in employer identification number or closure of the facility/ceasing services. The Provider agrees to provide DHS with a copy of the notice from the Internal Revenue Service verifying any change in a Taxpayer Identification Number.

X. The Provider may not delegate, assign, or subcontract the performance of any obligations contained in this Agreement.

Y. The Provider agrees to notify and submit a new Contract and Grant Disclosure and Certification Form to DHS within ten (10) days of the beginning of employment should the owner, a member of the owner's immediate family, or an authorized representative of the facility accept employment with the State of Arkansas. If a member of the Provider's Board of Directors is employed by the Provider and then accepts employment or does additional business with the State of Arkansas, the board member must submit a Contract and Grant Disclosure and Certification Form to DHS within ten (10) days of state employment or other business with the State of Arkansas.

Z. The Provider understands that this Agreement does not create an employer-employee relationship.

AA. The Provider agrees to accept responsibility for the reporting of funds received through DHS each calendar year. The Provider is responsible for the payment of all required federal and state taxes accrued.

BB. Providers who are incorporated must be registered with the Secretary of State's office and must remain in good standing to participate in the Arkansas ATR Program.

Appendix C

Arkansas Access to Recovery - Voluntary Consent Form

Introduction: Welcome to Arkansas Access to Recovery (AR ATR). AR ATR is a four-year Arkansas Department of Human Services (DHS), Division of Behavioral Health Services (DBHS), Office of Alcohol and Drug Abuse Prevention (OADAP) project funded by a grant from the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (SAMHSA). University of Arkansas for Medical Sciences (UAMS) Partners for Inclusive Communities (Partners) works with OADAP to manage the program. ATR provides opportunities for clients through use of a voucher system to purchase ATR covered services from providers with voucher agreements with AR DHS.

ATR services are based on client needs, agency policy, and current available ATR voucher funding, and are subject to change. Clients may participate in ATR for up to 12 months.

Information from the ATR project will help local, state, and federal providers and funding authorities improve alcohol and drug use disorder treatment and recovery services for you and others in your community.

Data Interviews: If you consent to participate in ATR, you will be asked to take part in **three GPRA data interviews** that take 15 to 45 minutes each. GPRA (Government Performance Results Act) interviews ask questions about alcohol and drug use, education and employment, family and living conditions, involvement in the criminal justice system, and participation in social support and recovery groups. You will receive a $15 dollar gift card for completing the GPRA Follow-up interview. In the event that during the attempted completion of the GPRA Follow-up Interview it is discovered that you're residing in a restricted setting, by signing this consent you grant your Care Coordination provider the ability to attempt contact with you which may include disclosure to the facility at which you reside of your involvement in ATR.

Release of Information: As part of your involvement in ATR, you are authorizing contact between AR DHS and SAMHSA and each provider you're receiving services from, to obtain information necessary for ATR project management. This may include, but is not limited to, information related to fiscal reporting, quality improvement, client progress, and data collection. By signing this form you are authorizing release of information between you and AR DHS and SAMHSA. You may revoke your release of information at any time except to the extent that action has already been taken. This consent expires automatically 6 months after your final GPRA interview.

Satisfaction Survey: You will be asked to complete an ATR Client Satisfaction Survey at the time you complete the GPRA Follow-up interview.

ATR is voluntary: You can refuse to participate in ATR or leave at any time. Refusal to participate in ATR will not affect any current or future substance abuse treatment you may receive. You may refuse to answer certain questions and still participate in ATR. If you refuse to answer a question, no one associated with ATR will seek the information you did not provide from some other source. If you participate in ATR and later choose not to participate, information you already have given will remain in the project.

Risks and Confidentiality: AR DHS, UAMS Partners and ATR providers take the privacy of your information seriously. ATR providers, AR DHS, UAMS Partners and SAMHSA must comply with confidentiality and protected health information requirements as set forth in Federal and State Confidentiality Regulations (42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, (160 & 164). Your records are protected and cannot be disclosed without your written consent.

Because AR ATR involves coordination of services you want, providers will ask you to sign a release of information to allow them to talk with other providers. You may revoke your release of information at any time except to the extent that action has already been taken. Generally, a program may not condition your services on whether you sign a release of information, however, in the special circumstances of the voluntary ATR project, you cannot participate if you do not sign the Voluntary Consent Form.

A unique identification number will be assigned to you as an ATR participant. Authorized representatives from AR OADAP or UAMS Partners may have access to records that identify you by name. Any information you provide that is part of aggregate data given to SAMHSA will not include your name or other identifying data. If any publications or presentations result from the ATR project, you will not be identified.

As part of your involvement in ATR you will receive services from a Care Coordination provider. To assist you with your involvement in ATR and utilization of services in your recovery, Care Coordination providers establish policies and determine the appropriate use of funding (i.e. amounts, frequency, services or vendors), up to the available limits, as it pertains to your goals in recovery. Services you receive will be from a community provider as arranged by your Care Coordinator and shall not represent a conflict of interest.

Client Rights: You have the right to:
- appropriate and considerate care and protection
- recognition and consideration of your cultural and spiritual values
- be told of all available ATR covered services and providers
- choose the services and providers you want from the list of available AR ATR covered services and providers
- refuse a recommended service or plan of care
- review records and information about your services
- expect providers, AR DHS, UAMS Partners, and SAMHSA to keep all communications and records confidential

Maintaining Involvement: If you do not receive at least one ATR service or participate in scheduled Care Coordination every 30 days, you will be discharged from the ATR program. By signing this form, you agree to these conditions in order to maintain involvement.

Questions: If you have questions or concerns about the ATR project, contact ATR Representative at DBHS OADAP at 501-686-9866 or through www.arkansas.gov/dhs/dmhs/ .

I have received, read, and understand the Access to Recovery - Voluntary Consent Form and all its contents. I agree to the conditions outlined above and choose to participate in the ATR program.

Client Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____
(if applicable)

Provider / Witness Signature: _____ Date: _____

Appendix E

Arkansas Access to Recovery - Release of Information

I, _____ authorize _____
(Client) (Care Coordination Provider)

to exchange information verbally and/or in writing with:

_____
(ATR Provider)

The nature and amount of the information shared will be as limited as possible, but may include:

Personal identifying information
- ☐ Participation and status in ATR covered services
- ☐ Drug test results
- ☐ Other (specify): _____

This consent is specific to my participation in Access to Recovery and will be used for care coordination, to monitor and evaluate services, and to submit claims to the Office of Alcohol and Drug Abuse Prevention.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted in writing. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically on the date on which all billing and reporting requirements related to my participation in Access to Recovery have been completely processed.

I understand that, generally, a program may not condition my services on whether I sign a release of information, however, in the special circumstances of the voluntary ATR project, I understand that I cannot participate if I do not sign a release of information.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if applicable)

Provider / Witness Signature _____ Date: _____

Appendix D

Access to Recovery - Collateral Contacts Form

The Access to Recovery project requires a GPRA Follow Up interview be completed for each client. To assist with this requirement, obtain at least three collateral contacts from the client to help in locating the client six months after intake. Collateral contacts can be individuals that have regular contact with the client (e.g. probation officers, family members, or case workers). Obtain a release of information from the client for each collateral contact.

Documentation of collateral contacts may be completed in the ATR VMS in lieu of completing this form.

Contact #1
Name:

Address:

Phones:

E-mail:

Contact #2
Name:

Address:

Phones:

E-mail:

Contact #3
Name:

Address:

Phones:

E-mail:

Form Approved
OMB No. 0930-0208
Expiration Date 04/30/2012

CSAT GPRA Client Outcome Measures for Discretionary Programs

Revised 9/13/2010

A. RECORD MANAGEMENT

Client ID |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Client Type:

- ○ Treatment client
- ○ Client in recovery

Contract/Grant ID |___|___|___|___|___|___|___|___|___|___|

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake [GO TO INTERVIEW DATE]

6 month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

3 month follow-up ***[FOR SELECT GFAs ONLY]*** →
Did you conduct a follow-up interview? ○ Yes ○ No ***[IF NO, GO DIRECTLY TO SECTION I.]***

Discharge → → → Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |___|___| / |___|___| / |___|___|___|___|
Month Day Year

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

1. Was the client screened by your program for co-occurring mental health and substance use disorders?

- ○ YES
- ○ NO [SKIP 1a.]

1a. [IF YES] **Did the client screen positive for co-occurring mental health and substance use disorders?**

- ○ YES
- ○ NO

SBIRT AND CAMPUS SBI CONTINUE. ALL OTHERS GO TO SECTION A "PLANNED SERVICES."

THIS SECTION IS FOR THE FOLLOWING GRANTS ONLY [REPORTED ONLY AT INTAKE/BASELINE]:
SBIRT (Items 2, 2a, & 3) and, CAMPUS SBI (Items 2 & 2a).

2. How did the client screen for your SBIRT or Campus SBI program?

O Negative

O Positive

2a. What was his/her screening score? AUDIT = |___|___|

CAGE = |___|___|

DAST = |___|___|

DAST-10 = |___|___|

NIAAA Guide = |___|___|

ASSIST/Alcohol Subscore = |___|___|

Other (Specify) _____ = |___|___|

_____

_____

_____

Campus SBI: GO TO SECTION A "PLANNED SERVICES."

3. Was he/she willing to continue his/her participation in the SBIRT program?

O YES

O NO

A. RECORD MANAGEMENT - PLANNED SERVICES *[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE]*

Identify the services you plan to provide to the client during the client's course of treatment/recovery. *[CIRCLE 'Y' FOR YES OR 'N' FOR NO FOR EACH ONE.]*

Modality *[SELECT AT LEAST ONE MODALITY.]*	**Yes**	**No**
1. Case Management	Y	N
2. Day Treatment	Y	N
3. Inpatient/Hospital (Other Than Detox)	Y	N
4. Outpatient	Y	N
5. Outreach	Y	N
6. Intensive Outpatient	Y	N
7. Methadone	Y	N
8. Residential/Rehabilitation	Y	N
9. Detoxification (Select Only One)		
A. Hospital Inpatient	Y	N
B. Free Standing Residential	Y	N
C. Ambulatory Detoxification	Y	N
10. After Care	Y	N
11. Recovery Support	Y	N
12. Other (Specify)_____	Y	N

[SELECT AT LEAST ONE SERVICE.]

Treatment Services *[SBIRT GRANTS: YOU MUST CIRCLE 'Y' FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]*	**Yes**	**No**
1. Screening	Y	N
2. Brief Intervention	Y	N
3. Brief Treatment	Y	N
4. Referral to Treatment	Y	N
5. Assessment	Y	N
6. Treatment/Recovery Planning	Y	N
7. Individual Counseling	Y	N
8. Group Counseling	Y	N
9. Family/Marriage Counseling	Y	N
10. Co-Occurring Treatment/ Recovery Services	Y	N
11. Pharmacological Interventions	Y	N
12. HIV/AIDS Counseling	Y	N
13. Other Clinical Services (Specify)_____	Y	N

Case Management Services	**Yes**	**No**
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	Y	N
2. Child Care	Y	N
3. Employment Service		
A. Pre-Employment	Y	N
B. Employment Coaching	Y	N
4. Individual Services Coordination	Y	N
5. Transportation	Y	N
6. HIV/AIDS Service	Y	N
7. Supportive Transitional Drug-Free Housing Services	Y	N
8. Other Case Management Services (Specify)_____	Y	N

Medical Services	**Yes**	**No**
1. Medical Care	Y	N
2. Alcohol/Drug Testing	Y	N
3. HIV/AIDS Medical Support & Testing	Y	N
4. Other Medical Services (Specify)_____	Y	N

After Care Services	**Yes**	**No**
1. Continuing Care	Y	N
2. Relapse Prevention	Y	N
3. Recovery Coaching	Y	N
4. Self-Help and Support Groups	Y	N
5. Spiritual Support	Y	N
6. Other After Care Services (Specify)_____	Y	N

Education Services	**Yes**	**No**
1. Substance Abuse Education	Y	N
2. HIV/AIDS Education	Y	N
3. Other Education Services (Specify)_____	Y	N

Peer-To-Peer Recovery Support Services	**Yes**	**No**
1. Peer Coaching or Mentoring	Y	N
2. Housing Support	Y	N
3. Alcohol- and Drug-Free Social Activities	Y	N
4. Information and Referral	Y	N
5. Other Peer-to-Peer Recovery Support Services (Specify)_____	Y	N

A. RECORD MANAGEMENT - DEMOGRAPHICS *[ASKED ONLY AT INTAKE/BASELINE]*

1. What is your gender?

- O MALE
- O FEMALE
- O TRANSGENDER
- O OTHER (SPECIFY) _____
- O REFUSED

2. Are you Hispanic or Latino?

- O YES
- O NO
- O REFUSED

***[IF YES]* What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	Yes	No	Refused
Central American	Y	N	REFUSED
Cuban	Y	N	REFUSED
Dominican	Y	N	REFUSED
Mexican	Y	N	REFUSED
Puerto Rican	Y	N	REFUSED
South American	Y	N	REFUSED
Other	Y	N	REFUSED *[IF YES, SPECIFY BELOW]*
	(Specify) _____		

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	Y	N	REFUSED
Asian	Y	N	REFUSED
Native Hawaiian or other Pacific Islander	Y	N	REFUSED
Alaska Native	Y	N	REFUSED
White	Y	N	REFUSED
American Indian	Y	N	REFUSED

4. What is your date of birth?*

|__|__| / |__|__| / *[*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR. TO MAINTAIN CONFIDENTIALITY DAY IS NOT SAVED.]*
MONTH DAY

|__|__|__|__|
YEAR

- O REFUSED

5. Are you a veteran?

- O YES
- O NO
- O REFUSED
- O DON'T KNOW

B. DRUG AND ALCOHOL USE

		Number of Days	REFUSED	DON'T KNOW
1.	**During the past 30 days, how many days have you used the following:**			
a.	Any alcohol *[IF ZERO, SKIP TO ITEM B1c.]*	____	O	O
b1.	Alcohol to intoxication (5+ drinks in one sitting)	____	O	O
b2.	Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	____	O	O
c.	Illegal drugs *[IF B1a <u>OR</u> B1c = 0, RF, DK, THEN SKIP TO ITEM B2.]*	____	O	O
d.	Both alcohol and drugs (on the same day)	____	O	O

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

		Number of Days	RF	DK	Route*	RF	DK
2.	**During the past 30 days, how many days have you used any of the following:** ***[IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]***						
a.	Cocaine/Crack	____	O	O	___	O	O
b.	Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	____	O	O	___	O	O
c.	Opiates:						
	1. Heroin (Smack, H, Junk, Skag)	____	O	O	___	O	O
	2. Morphine	____	O	O	___	O	O
	3. Diluadid	____	O	O	___	O	O
	4. Demerol	____	O	O	___	O	O
	5. Percocet	____	O	O	___	O	O
	6. Darvon	____	O	O	___	O	O
	7. Codeine	____	O	O	___	O	O
	8. Tylenol 2,3,4	____	O	O	___	O	O
	9. Oxycontin/Oxycodone	____	O	O	___	O	O
d.	Non-prescription methadone	____	O	O	___	O	O
e.	Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel) MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms or Mescaline	____	O	O	___	O	O
f.	Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)	____	O	O	___	O	O

B. DRUG AND ALCOHOL USE (Continued)

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: ***[IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]***

			Number of Days	RF	DK	Route*	RF	DK
g.	1.	Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol–also known as roofies, roche, and cope)	____	O	O	___	O	O
	2.	Barbiturates: Mephobarbital (Mebacut); and pentobarbital sodium (Nembutal)	____	O	O	___	O	O
	3.	Non-prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy)	____	O	O	___	O	O
	4.	Ketamine (known as Special K or Vitamin K)	____	O	O	___	O	O
	5.	Other tranquilizers, downers, sedatives or hypnotics	____	O	O	___	O	O
h.		Inhalants (poppers, snappers, rush, whippets)	____	O	O	___	O	O
i.		Other illegal drugs (Specify) _____	____	O	O	___	O	O

3. In the past 30 days have you injected drugs? ***[IF ANY ROUTE OF ADMINISTRATION IN B2a THROUGH B2i = 4 or 5, THEN B3 MUST = YES.]***

- O YES
- O NO
- O REFUSED
- O DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW SKIP TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton or water that someone else used?

- O Always
- O More than half the time
- O Half the time
- O Less than half the time
- O Never
- O REFUSED
- O DON'T KNOW

C. FAMILY AND LIVING CONDITIONS

1. **In the past 30 days, where have you been living most of the time?** ***[DO NOT READ RESPONSE OPTIONS TO CLIENT.]***

- ○ SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- ○ STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- ○ INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- ○ HOUSED: ***[IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]***
  - ○ OWN/RENT APARTMENT, ROOM, OR HOUSE
  - ○ SOMEONE ELSE'S APARTMENT, ROOM OR HOUSE
  - ○ DORMITORY/COLLEGE RESIDENCE
  - ○ HALFWAY HOUSE
  - ○ RESIDENTIAL TREATMENT
  - ○ OTHER HOUSED (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

2. **During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?** ***[IF B1a <u>OR</u> B1c > 0, THEN C2 CANNOT = " NOT APPLICABLE".]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1a <u>AND</u> B1c = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

3. **During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?** ***[IF B1a <u>OR</u> B1c > 0, THEN C3 CANNOT = " NOT APPLICABLE".]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1a <u>AND</u> B1c = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? ***[IF B1a OR B1c > 0, THEN C4 CANNOT = " NOT APPLICABLE".]***

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE ***[USE ONLY IF B1a AND B1c = 0.]***
- ○ REFUSED
- ○ DON'T KNOW

5. ***[IF NOT MALE,]*** **Are you currently pregnant?**

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

6. Do you have children?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW SKIP TO SECTION D.]

a. How many children do you have? ***[IF C6 = YES, THEN A VALUE IN C6a MUST BE > 0.]***

|___|___| ○ REFUSED ○ DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW SKIP TO ITEM C6d.]

c. ***[IF YES,]*** **How many of your children are living with someone else due to a child protection court order?** ***[THE VALUE IN C6c CANNOT EXCEED THE VALUE IN C6a.]***

|___|___| ○ REFUSED ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

d. For how many of your children have you lost parental rights? ***[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.][THE VALUE IN ITEM C6d CANNOT EXCEED THE VALUE IN C6a.]***

|___|___| O REFUSED O DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? ***[IF ENROLLED,]*** **Is that full time or part time?** ***[IF CLIENT IS INCARCERATED CODE D1 AS "NOT ENROLLED."]***

- O NOT ENROLLED
- O ENROLLED, FULL TIME
- O ENROLLED, PART TIME
- O OTHER (SPECIFY)_____
- O REFUSED
- O DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

- O NEVER ATTENDED
- O 1ST GRADE
- O 2ND GRADE
- O 3RD GRADE
- O 4TH GRADE
- O 5TH GRADE
- O 6TH GRADE
- O 7TH GRADE
- O 8TH GRADE
- O 9TH GRADE
- O 10TH GRADE
- O 11TH GRADE
- O 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- O COLLEGE OR UNIVERSITY/1st YEAR COMPLETED
- O COLLEGE OR UNIVERSITY/2nd YEAR COMPLETED/ASSOCIATES DEGREE (AA, AS)
- O COLLEGE OR UNIVERSITY/3rd YEAR COMPLETED
- O BACHELOR'S DEGREE (BA, BS) OR HIGHER
- O VOC/TECH PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
- O VOC/TECH DIPLOMA AFTER HIGH SCHOOL
- O REFUSED
- O DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME (Continued)

3. Are you currently employed? ***[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK. [IF CLIENT IS "ENROLLED, FULL TIME" IN D1 AND INDICATES "EMPLOYED FULL TIME" IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "UNEMPLOYED, NOT LOOKING FOR WORK."]***

- O EMPLOYED FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- O EMPLOYED PART TIME
- O UNEMPLOYED, LOOKING FOR WORK
- O UNEMPLOYED, DISABLED
- O UNEMPLOYED, VOLUNTEER WORK
- O UNEMPLOYED, RETIRED
- O UNEMPLOYED, NOT LOOKING FOR WORK
- O OTHER (SPECIFY) _____
- O REFUSED
- O DON'T KNOW

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from... ***[IF D3 DOES NOT = "EMPLOYED" AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = "UNEMPLOYED, LOOKING FOR WORK" AND THE VALUE IN D4b = 0, PROBE. IF D3 = "UNEMPLOYED, RETIRED" AND THE VALUE IN D4c = 0, PROBE. IF D3 = "UNEMPLOYED, DISABLED" AND THE VALUE IN D4d = 0, PROBE.]***

			RF	DK
a.	Wages	$ ___, ___	O	O
b.	Public assistance	$ ___, ___	O	O
c.	Retirement	$ ___, ___	O	O
d.	Disability	$ ___, ___	O	O
e.	Non-legal income	$ ___, ___	O	O
f.	Family and/or friends	$ ___, ___	O	O
g.	Other (Specify) _____	$ ___, ___	O	O

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES O REFUSED O DON'T KNOW

[IF NO ARRESTS, SKIP TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses? ***[THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]***

|____|____| TIMES O REFUSED O DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS (Continued)

3. In the past 30 days, how many nights have you spent in jail/prison? ***[IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]***

|___|___| NIGHTS O REFUSED O DON'T KNOW

4. In the past 30 days, how many times have you committed a crime? ***[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 4. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]***

|___|___|___| TIMES O REFUSED O DON'T KNOW

5. Are you currently awaiting charges, trial, or sentencing?

- O YES
- O NO
- O REFUSED
- O DON'T KNOW

6. Are you currently on parole or probation?

- O YES
- O NO
- O REFUSED
- O DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

- O Excellent
- O Very good
- O Good
- O Fair
- O Poor
- O REFUSED
- O DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Cont.)

2. During the past 30 days, did you receive:

a. Inpatient Treatment for:

	YES	*[IF YES]* Altogether for how many nights	NO	RF	DK
i. Physical complaint	O	_____ nights	O	O	O
ii. Mental or emotional difficulties	O	_____ nights	O	O	O
iii. Alcohol or substance abuse	O	_____ nights	O	O	O

b. Outpatient Treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	O	_____ times	O	O	O
ii. Mental or emotional difficulties	O	_____ times	O	O	O
iii. Alcohol or substance abuse	O	_____ times	O	O	O

c. Emergency Room Treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	O	_____ times	O	O	O
ii. Mental or emotional difficulties	O	_____ times	O	O	O
iii. Alcohol or substance abuse	O	_____ times	O	O	O

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Cont.)

3. During the past 30 days, did you engage in sexual activity?

- ○ Yes
- ○ No → *[SKIP TO F4.]*
- ○ NOT PERMITTED TO ASK → *[SKIP TO F4.]*
- ○ REFUSED → *[SKIP TO F4.]*
- ○ DON'T KNOW → *[SKIP TO F4.]*

[IF YES] **Altogether, how many:**

	Contacts	RF	DK
a. Sexual contacts (vaginal, oral, or anal) did you have?	___	○	○
b. Unprotected sexual contacts did you have? ***[THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.]***	___	○	○
c. Unprotected sexual contacts were with an individual who is or was: ***[NONE OF THE VALUES IN F3c1 THROUGH F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]***			
1. HIV positive or has AIDS	___	○	○
2. An injection drug user	___	○	○
3. High on some substance	___	○	○

4. Have you ever been tested for HIV?

- ○ Yes..... [GO TO F4a.]
- ○ No..... [SKIP TO F5.]
- ○ REFUSED..... [SKIP TO F5]
- ○ DON'T KNOW..... [SKIP TO F5.]

4a. Do you know the results of your HIV testing?

- ○ Yes
- ○ No

5. **In the past 30 days, not due to your use of alcohol or drugs, how many days have you:**

		Days	RF	DK
a.	Experienced serious depression	____	○	○
b.	Experienced serious anxiety or tension	____	○	○
c.	Experienced hallucinations	____	○	○
d.	Experienced trouble understanding, concentrating, or remembering	____	○	○
e.	Experienced trouble controlling violent behavior	____	○	○
f.	Attempted suicide	____	○	○
g.	Been prescribed medication for psychological/emotional problem	____	○	○

[IF CLIENT REPORTS ZERO DAYS, RF OR DK TO ALL ITEMS IN QUESTION 5, SKIP TO SECTION G.]

6. **How much have you been bothered by these psychological or emotional problems in the past 30 days?**

○ Not at all
○ Slightly
○ Moderately
○ Considerably
○ Extremely
○ REFUSED
○ DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. **In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.**

   O YES *[IF YES]* SPECIFY HOW MANY TIMES _____ O REFUSED O DON'T KNOW
   O NO
   O REFUSED
   O DON'T KNOW

2. **In the past 30 days, did you attend any religious/faith affiliated recovery self-help groups?**

   O YES *[IF YES]* SPECIFY HOW MANY TIMES _____ O REFUSED O DON'T KNOW
   O NO
   O REFUSED
   O DON'T KNOW

3. **In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?**

   O YES *[IF YES]* SPECIFY HOW MANY TIMES _____ O REFUSED O DON'T KNOW
   O NO
   O REFUSED
   O DON'T KNOW

4. **In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?**

   O YES
   O NO
   O REFUSED
   O DON'T KNOW

5. **To whom do you turn when you are having trouble?** ***[SELECT ONLY ONE.]***

   O NO ONE
   O CLERGY MEMBER
   O FAMILY MEMBER
   O FRIENDS
   O REFUSED
   O DON'T KNOW
   O OTHER SPECIFY: _____

I. FOLLOW-UP STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP]

1. What is the follow-up status of the client? ***[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED].***

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed interview within specified window
- ○ 12 = Completed interview outside specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other (SPECIFY) _____

2. Is the client still receiving services from your program?

- ○ Yes
- ○ No

[IF THIS IS A FOLLOW-UP INTERVIEW STOP NOW, THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS
[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

1. On what date was the client discharged?

|__|__| / |__|__| / |__|__|__|__|
MONTH DAY YEAR

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

  If the client was terminated, what was the reason for termination? [*SELECT ONE RESPONSE.*]
  - ○ 01 = Left on own against staff advice with satisfactory progress
  - ○ 02 = Left on own against staff advice without satisfactory progress
  - ○ 03 = Involuntarily discharged due to nonparticipation
  - ○ 04 = Involuntarily discharged due to violation of rules
  - ○ 05 = Referred to another program or other services with satisfactory progress
  - ○ 06 = Referred to another program or other services with unsatisfactory progress
  - ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
  - ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
  - ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
  - ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
  - ○ 11 = Transferred to another facility for health reasons
  - ○ 12 = Death
  - ○ 13 = Other (Specify)_____

3. Did the program test this client for HIV?

- ○ Yes..... [SKIP TO SECTION K.]
- ○ No..... [GO TO J4.]

4. [IF NO] Did the program refer this client for testing?

- ○ Yes
- ○ No

K. SERVICES RECEIVED
[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]***

Modality	Days
1. Case Management	
2. Day Treatment	
3. Inpatient/Hospital (Other Than Detox)	
4. Outpatient	
5. Outreach	
6. Intensive Outpatient	
7. Methadone	
8. Residential/Rehabilitation	
9. Detoxification (Select Only One)	
A. Hospital Inpatient	
B. Free Standing Residential	
C. Ambulatory Detoxification	
10. After Care	
11. Recovery Support	
12. Other (Specify) _____	

Identify the number of SESSIONS provided to the client during the client's course of treatment/ recovery. ***[ENTER ZERO IF NO SERVICES PROVIDED.]***

Treatment Services	Sessions
[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]	
1. Screening	
2 Brief Intervention	
3. Brief Treatment	
4. Referral to Treatment	
5. Assessment	
6. Treatment/Recovery Planning	
7. Individual Counseling	
8. Group Counseling	
9. Family/Marriage Counseling	
10. Co-Occurring Treatment/ Recovery Services	
11. Pharmacological Interventions	
12. HIV/AIDS Counseling	
13. Other Clinical Services (Specify) _____	

Case Management Services	Sessions
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	
2. Child Care	
3. Employment Service	
A. Pre-Employment	
B. Employment Coaching	
4. Individual Services Coordination	
5. Transportation	
6. HIV/AIDS Service	
7. Supportive Transitional Drug-Free Housing Services	
8. Other Case Management Services (Specify) _____	

Medical Services	Sessions
1. Medical Care	
2. Alcohol/Drug Testing	
3. HIV/ AIDS Medical Support & Testing	
4. Other Medical Services (Specify) _____	

After Care Services	Sessions
1. Continuing Care	
2. Relapse Prevention	
3. Recovery Coaching	
4. Self-Help and Support Groups	
5. Spiritual Support	
6. Other After Care Services (Specify) _____	

Education Services	Sessions
1. Substance Abuse Education	
2. HIV/AIDS Education	
3. Other Education Services (Specify) _____	

Peer-To-Peer Recovery Support Services	Sessions
1. Peer Coaching or Mentoring	
2. Housing Support	
3. Alcohol- and Drug-Free Social Activities	
4. Information and Referral	
5. Other Peer-to-Peer Recovery Support Services (Specify) _____	

Recovery Support Services Questionnaire

General:

Interviewer:		Interview Start Date:	
Created by:			
Updated by:			

Interviewer:
Good morning/afternoon/evening. Thank you for coming in today. My name is _____ and I'll be asking you questions about your goals and needs for the next 30 minutes or so. My goal is to help you find the services that will best support you in recovery. If you have questions at any time during our conversation, please don't hesitate to ask.

Do you have any questions before we start?

All right, then. Let's confirm your name and date of birth.

Participant Name:		Date of Birth:	

Unable to induct the interview due to the client's intoxication level and/or mental status:

True:		False:	

Goals and Motivation:

Interviewer: *OK, I'm going to ask you some questions about the reason you're here today, how you feel about being here, and your goals.*

G1. What brought you here today?

Self-referral		Court		Other Description:	
Corrections		Family		Child Welfare	
School		Employer		Physician	
Treatment Provider		Recovery Support Services Provider		Church/Congregation	
Other (Specify)					

G2. How do you feel about being here today? *(Select all that apply.)*

Angry		Excited		Uncertain	
Anxious		Hopeful		Other (specify)	
Determined		Resigned			
Other description:					

G3. What would you like to accomplish through working with us? (Select all that apply - at least one answer is required.)

Reduce/Manage Alcohol/Drug Use		Improve relationship with spouse/partner/family		Keep job	
Get support in recovery		Keep spouse/partner/family		Get job	
Connect with others in recovery		Get spouse/partner/family back		Avoid Jail	
Meet legal requirements		Maintain custody of children		Obtain food, clothing, or housing	
Other (specify)		Regain custody of children		Stop using drugs/Alcohol	
Other description:					

Interviewer: *You said your goal(s) in working with us is/are to* ***(restate goals from above).***

If more than one goal is identified, ask the interviewee the following question: Which of these goals is most important to you?

If three (3) or more goals are identified, ask the following question: *Which of these goals are the second and third most important to you?*

G4. Enter goals in order of priority in the fields below, leaving any unneeded goals fields blank:

Goal 1:	
Goal 2:	
Goal 3:	

Interviewer: Great! Now I'm going to ask you about how confident you are that you will be able to accomplish your goal(s):

G5. On a scale of 1-10 with (10) being *Very Confident*, and (1) being *Not Confident at All,* how confident re you that you will be able to accomplish these goal(s)?

1 – Not Confident at All
2
3
4
5
6
7
8

9
10 – Very Confident

G6. On a scale of 1-10, with 10 being *Very Ready* and 1 being *Not Ready at All*, how ready are you to start working on your goal(s) today?

1 – Not Ready at All
2
3
4
5
6
7
8
9
10 – Very Ready

Interviewer Summary Comment – Goals and Motivation:

Transportation:

Interviewer: *OK, our next topic is transportation.*

T1. Do you have a valid driver's license?

No
Yes

T2. Would you like help getting a valid driver's license?

No
Yes

T3. Is there anything that might keep you from getting a driver's license?

No	
Yes (Specify)	
Description:	

T4. Do you have a reliable way to get around?

Yes, has reliable car
Yes, can walk or ride bike where I need to go
Yes, has access to public or private transportation, reliable car or can reliably get ride
No, limited or no access to public transportation
No money for transportation
Transportation unavailable or unreliable

T5. Do you have any special transportation needs?

No	
Need wheelchair/handicap access	
Special needs due to physical mobility restrictions	
Special needs due to visual impairment	
Special needs due to hearing impairment	
Other (Specify)	
Description:	

T6. Would you like help lining up dependable transportation?

No
Yes

Interviewer Summary Comment – Transportation:

Employment:

Interviewer: *So far so good? (If the interviewee has concerns or questions, please respond to them before proceeding.)*

Interviewer: *Now I have some questions about employment.*

E1. Do you have a job?

No

Yes

E2. Which of these describe your situation? *(Select all that apply.)*

I was laid off		I can't find a job due to legal problems	
I was fired		I choose not to work	
I quit my job		I am a full-time student	
I have been out of work for 3 months or more		Someone supports me	
I want to work, but have given up on finding work		I am retired	
I am actively looking for work		I recently got out of jail or another controlled environment	
I want to work, but have given up on finding a job		I am unable to work due to a disability	
Other (specify)			
Other Description:			

E3. Which of these describe your situation? *(Check all that apply.)*

I work full time (35+ hours per week)		I am looking for a new job	
I work part time (regular hours)		My job doesn't pay well enough to make ends meet	
I work part time (irregular hours or day work)		I have more than one job	
I am in the military or another service		My job is good for my recovery	
I do volunteer work only		My job is not good for my recovery	
I like my job		My job situation does not affect my recovery	
I don't like my job			

E4. What skills or experience do you have that might help you if you wanted to find or keep a job? *(Check all that apply.)*

Child Care		Office Management		Supervision	
Customer Service		Profession (e.g., accounting, law, social work)		Warehouse	
Healthcare		Retail Sales		Delivery	
Landscaping or Gardening		Retail Management		Trucking	
Business Management		Sales		Trade	
Other (specify)					
Other Description:					

E5. Are there skills that you would like to develop or experience that you'd like to gain? *(Check all that apply.)*

Computer skills/technology		**Commercial driver's license**	
Office skills		**Math/Science**	
Child care		**Writing skills**	
Sales		**Supervisory management skills**	
Speaking skills		**Language/ESL**	
Trade skills (plumbing, electrical, construction etc)		**Other (specify)**	

E6. Is your job situation in jeopardy, meaning that you could lose your job at any time?

Yes (Please Explain)		**No**	

If "Yes" - Explanation:

E7. What responsibilities do you have outside work?

Child care		Household chores	
Care of elderly, disabled or ill family member		Mandatory reporting requirement (probation)	
School and homework		Other (specify)	
Other Description:			

E8. Do you think your responsibilities and schedule will 1) help you reach your recovery goals, 2) get in the way of reaching them, or 3) not affect them one way or the other?

Help me reach goals
Get in the way of reaching goals
Not affect my ability to reach my goals
Unsure

E9. If your responsibilities and/or schedule would get in the way of reaching your goals, what responsibility or scheduling issue would most get in your way?

Other Description:

Interviewer: *Now I'm going to ask you to rate your need for employment-related services.*

E10. On a scale of (1-10), with (10) meaning you have immediate and extensive need for employment services and 1) meaning you have no need for employment services, how would you rate yourself?

1 – No Needs
2
3
4
5
6
7
8
9
10 – immediate and extensive need for employment counseling

E11. Would you like help with any employment or work-related matters?

Yes		**No**	

E11b. What employment or work-related matters do you want help with?

E12. What responsibility or scheduling issue would most get in your way?

Vocational assessment		Arranging job interviews	
Help finding a job or maintaining employment		Interviewing skills	
Employment barriers related to a felony conviction		Disability evaluation	
Developing a resume		Disability @ work rehabilitation	
Other (specify)		Getting a promotion, better job or skills	

Interviewer Summary Comment – Employment

School and Training:

Interviewer: *OK, I have some questions about school and training.*

Interviewer: ***Only ask this question if English is a second language for the interviewee and English as a second language classes might be helpful. Otherwise, check "Not Applicable."***

ST1. Would you like help finding English as a Second Language classes?

No
Yes
Not Applicable

ST2. What is the highest level of education you have finished, whether or not you received a degree?

Never attended
1st Grade
2nd Grade
3rd Grade
4th Grade
5th Grade
6th Grade
7th Grade
8th Grade
9th Grade
10th Grade
11th Grade
12th Grade/High School Diploma/Equivalent
College or University/1st Year Completed
College or University/2nd Year Completed/ Associates Degree (Aa, As)
College or University/ 3rd Year Completed
Bachelor's Degree (Ba, Bs) or Higher
Voc/Tech Program after High School but no Voc/Tech Diploma
Voc/Tech Diploma after High School
Declined
Don't Know

ST3. Are you currently in school or other training?

Yes		**No**	

ST4. If "Yes" - Which best describes your situation?

ST5. Do you think additional training or education would help you in your recovery?

Yes
No

ST6. Are you interested in getting help with any of the following? *(Check all that apply.)*

Earning a GED		Aptitude and achievement testing	
Academic counseling or tutoring		Technical or vocational training	
Grants, loans or scholarships for additional education		Literacy training	
Finding or applying to schools		Going back to school	
Other (specify)			
Other Description:			

Interviewer Summary Comment:

Housing and Recovery Environment:

Interviewer: *Our next topic is your living environment.*

H1. Who do you live with?

With a spouse/domestic partner and child/children
With spouse/domestic partner alone
With child/children alone
With parent(s)
With other family
With friends
Alone
In a controlled environment (e.g. community corrections/work release program)
Homeless or no stable arrangements
Temporary arrangements
In a group living facility

H2. Do you own or rent the place where you live?

Rent
Own
Other (Specify)

H3. Are you concerned about losing your housing?

No
Yes – Eviction
Yes – Foreclosure
Yes – other (specify)

H4. Which of the following best describes your living situation?

The people I live with are in recovery or will actively support my recovery.
The people I live with will permit, but not support, my recovery.
The people I live with will not be very supportive of my recovery.
The people I live with will keep alcohol and drugs in the house, use drugs and alcohol in my presence, sell drugs or actively discourage my recovery.

H5. Is anyone in your environment threatening, intimidating or harming you, your children, or anyone else in our household verbally, physically, or sexually?

No
Yes

H6. Which of these describes the situation? *(Check all that apply.)*

Threatening		Physically abusing	
Intimidating		Sexually abusing	
Verbally abusing		Interviewee did not want to respond	

Interviewer:

Life Safety: Your organization should have clear policies for responding to reports of current abuse that comply with state and federal laws. You are a representative your organization may be legally required to notify child welfare or law enforcement agencies if violence or threats of violence are reported to you by a participant. If the interviewee reports threats, intimidation, or any kind of verbal, physical or sexual abuse, please consult your organization's policies.

Interviewer: *OK, Now I am going to use a 10 point scale to describe how safe you feel in your living situation and neighborhood.*

H7. On a scale of 1-10, where 1 means your home or living environment is safe and 10 means you are in a dangerous environment where you or a member of your family could be hurt at any time, how would you rate your home environment and neighborhood?

1 – Safe
2
3
4
5
6
7
8
9
10 - Dangerous

H8. If your living environment is not safe, would you like help finding a safer place to live?

H9. I'm going to read some statements about the neighborhood where you live. Let me know which of these apply to your situation. You can choose as many as apply.

My neighborhood feels safe to me.	
My neighborhood is a good place to start or continue my recovery.	
My neighborhood is dangerous or stressful to live in.	
There are many drug dealers or liquor stores in my neighborhood.	
I regularly see people I used or drank with in my neighborhood.	
My neighborhood is NOT a good place to start or continue my recovery.	
Other (specify):	
Other Description:	

Interviewer: *Now I'm going to ask you to use a 10 point scale again. This time I'm going to ask you to tell me how supportive of your recovery you think your current environment is. By living environment I mean those who live with you, the building you live in if you're in an apartment building, and the neighborhood where you live. OK?*

H10. On a scale of 1-10, where 1 means your living environment is supportive of recovery and 10 means your living environment puts you at high risk of using drugs or alcohol, how would you rate your home environment and neighborhood?

1 – Supportive of recovery
2
3

4
5
6
7
8
9
10 – Risk of relapse

H11. ***If participant responds that her/his living environment is not supportive of recovery, then ask,*** Would you like help finding a more recovery-friendly place to live?

Interviewer: *There are different kinds of housing and housing assistance. I'm going to tell you about some kinds of help that are available. Let me know if any of these are of interest to you or if you would like a different kind of help related to housing. OK?*

H12. Are you interested in learning about help related to any of the following?

Emergency or temporary housing		Supported independent living	
Recovery home, or other clean and sober housing		Housing barriers related to a felony conviction	
Independent stable housing		Help finding subsidized housing	
Other (specify)			
Other Description:			

Interviewer Summary Comment – Housing and Recovery Environment:

Recovery Status:

Interviewer: *Now I'm going to ask you some questions about your recovery status and services that might help you in recovery. What's important to remember here is that I'm here for you and you don't need to tell me what you think I might want to hear. OK? We'll work with you from wherever you're at. The better we understand that, the better we can be of help to you. OK?*

R1. Which of the following statements best describes where you are personally?

I do not have an alcohol or drug problem		I have not used for one week or more.	
I'm in recovery and have not used alcohol or other drugs for one year or more.		I have used at least one substance during the past week.	
I'm in early recovery and have not used		I am actively using one or more	

for 3 months or more.		substances	

R2. Do you have a recovery plan?

Yes- Up-to-Date		No	
Yes- Needs to be Updated			

R3. ***If "Yes"*** - Would you like help updating your plan?

No
Yes

R4. ***If "No"*** - Would you like help creating a plan?

R5. Do you have a case manager, recovery support services coordinator, recovery coach, or other person who helps you meet your recovery plan?

No
Yes (Specify)

R6. Is there a friend, family member, pastor or other community member you look to when you need help?

No
Yes (Specify)

R7. Are you interested I connecting with someone in recovery who has had similar experiences to yours and might be able to help you in recovery?

No
Yes

R8. Do you know of a recovery organization or recovery events in your neighborhood?

No
Yes (Specify)

R9. Would you like to connect with recovering people to take part in recovery events?

No
Yes

R10. Do you think treatment or recovery services might help you reach your recovery goals?

No
Yes
Unsure

R11. Would you like to learn about the kinds of treatment and recovery services that are available?

No
Yes

R12. Are there any specific kinds of treatment or recovery services that you think might be helpful to you?

R13. Would you like to learn about the different kinds of support groups in your area or how to locate a group?

No, already involved
No, not interested
Uncertain or ambivalent
Yes

R14. Would you like someone who attends those groups to call you so you can learn more first-hand?

R15. Do you smoke?

R16. Would you like help to quit smoking?

No
Yes (Specify)

R17. Have you discovered things that might help you to enter or stay in recovery? *(If "Yes," examples below)*

Other people in recovery		Faith or spiritual groups/practices	

Friends		Cultural activities/groups	
Recovery/support group		Meditation/relaxation	
Volunteer work		Leisure activities	
Other(specify)			
Other description:			

Interviewer Summary Comment – Recovery Status:

Talents, Recreation, and Leisure:

Interviewer: *The next set of questions is about hobbies, sports, and other activities that you enjoy.*

Tal1. Are there hobbies or recreational or leisure activities that you enjoy or would like to try?
Interviewer: *List activities discussed, including any ideas, comments, or recommendations.*

No
Yes (Specify)

Tell me about these activities.

Tal2: Are you involved in any of these activities right now? *(If so, specify):*

(Specify)

Tal3: ***(If "No")*** Do you know how you could get involved in those activities or hobbies?

Tal4: Would you like help in getting involved in those activities are hobbies?

Interviewer Summary Comment – Talent, Recreation, and Leisure:

Spiritual:

Interviewer: *OK, I have two questions about spirituality and religion.*

S1. Some spiritual and religious groups have organized to offer support to people in recovery. Are you interested in learning about spirituality or faith-based support and/or services?

No
Yes

S2. Is there a specific faith, tradition, or spiritual practice you think might help you achieve your recovery goals?

Interviewer Summary Comment – Spiritual:

Culture, Gender and Sexual Orientation:

Interviewer: *Now I'm going to ask you about some personal preferences, about military service and experience in a war zone, and about your heritage/ethic background.*

C1. Do you have a preference about the culture, race/ethnicity or sex of the individuals from whom you receive services?

No preference		Gender	
Language		Sexual Orientation	
Culture, ethnicity, race		Veteran's status	
Other (specify)			
Other description:			

C2. Do you have a preference about the type of organization or community where you receive services?

No preference		Gender	
Language		Sexual Orientation	
Culture, ethnicity, race		Veteran's status	
Other (specify)			
Other description:			

C3. How important are those preferences?

Not very important
Somewhat important
Important
Very Important

C4. Would you like help finding services that match your preferences?

No
Yes

C5. Are you a veteran or a member of the armed forces?

No
Active Duty
Veteran
Current Guard or Reserve Member
Former Guard or Reserve Member

C6. Have you served, worked, or lived in a war zone?

No
Yes, as member of military
Yes, in contractor role
Yes, as civilian

C7. As a current or former member of the armed services, so you know what services you are entitled to and how you can access them?

No
Yes

C8. Would you like special assistance for issues related to your experience in a war zone or your return to the community?

No
Yes

C9. Are you Hispanic or Latino?

No
Yes
Decline

C10. ***If "Yes"*** - What is your heritage? *(You may select more than one.)*

Central American		Mexican	
Cuban		Puerto Rican	
Dominican		South American	
Other			
Other description:			

C11. What is your sex?

Male
Female
Decline
Other (Specify)

C12. What is your race or ethnicity?

Black or African American		White	
Asian		American Indian	
Native Hawaiian other Pacific Islander		Arab American or Middle Eastern	
Alaska Native		Declined	
Other (specify):			

C13. Do you consider yourself "Straight" (heterosexual), "gay" (homosexual, lesbian) or bisexual?

Straight/heterosexual
Gay/homosexual/lesbian
Bisexual
Not Sure
Decline

C14. Would you describe yourself as transgendered?

No
Yes
Declined

Interviewer Summary Comment – Culture, Gender and Sexual Orientation:

Medical:

Interviewer: *OK. Now we're moving to some questions about medical services.*

M1. Do you believe you are currently receiving the medical care and services that you need?

No
Yes
Not Sure

M2. Do you have a doctor or clinic you can go to?

1 - Yes, satisfied with current situation
2- Yes, but would like help finding a new provider
3 – No, would like help finding a provider
4 – No, does not want help
5 – Other (Specify)

Other Description:

M3. I'm going to read a list of a few medical services. Would you let me know if you need any of these or any other medical services?

Treatment or medication for a condition		Dental care	
Physical Exam/Checkup		Glasses or other visual assistance	
Help with physical mobility		None	

Help with hearing problem		Not sure	
Other (specify)			
Other description:			

M4. **Interviewer:** ***Specify the known condition(s) for which treatment is needed. Do not include treatment for substance use and mental health psychiatric conditions.***

High blood pressure		Hepatitis	
Diabetes		HIV	
High cholesterol		TB	
Asthma		Cirrhosis	
Heart disease		Atherosclerosis (hardening of the arteries)	
Other (specify):		Declined	
Other description:			

M5. Do you need help with *(Check all that apply)*

Getting free of low-cost health care?		Applying for Medicaid , SSI/SSD, or health insurance	

M6. Do you know whether or not you are HIV positive?

Yes, positive
Yes, negative
No
Not sure
Decline to Answer
Skip question (interviewer)

M7. **If "Yes,"** Would you like help with any of the following related to your HIV condition?

Obtaining medications		Education about HIV and safer sex	
Keeping on schedule with or managing my appointments		Support groups	
Access to and payment for HIV-related care		In-home care or support	
Transportation to and from appointments		Residential care	
Other (specify)			

M8. Are you pregnant?

Yes		No	

M9. Would you like to take a pregnancy test so that you can get prenatal care if you need it?

M10. ***If "Are you pregnant = "Yes,"*** Would you like help with any of the following?

Setting up prenatal care		Obtaining newborn/lactation education	
Obtaining pregnancy /childbirth education		Getting to appointments	
Other (specify)		No help needed	

M11. Would you like to talk to someone about whether or not you should be tested for infectious or communicable diseases such as TB, Hepatitis C or sexually transmitted diseases?

No
Yes
Other (Specify)

M12. Do you think psychiatric and/or mental health services might help you in your recovery?

No
Yes
Unsure
Not applicable
Declined

Interviewer: ***(Do not include any alcohol or drug service needs with this item.)***

M13. Are you receiving psychiatric or mental health services now?

No , would like help finding services
No, does not want psychiatric or mental health services
Yes, satisfied with current situation
Yes, but would like to find new provider
Declined

M14. Are there specific kinds of psychiatric or mental health services that you think might help you in your recovery?

No		Medication	
Treatment for known condition(s)		Counseling	

Psychiatric evaluation		Therapy	
Medication evaluation		Not sure	
Other (specify)			
Other description:			

M15. **Interviewer:** ***Specify known condition(s)***

M16. Would you like help finding psychiatric or mental health services or getting an evaluation to see if they might help?

No
Yes , services
Yes, evaluation

M17. Are you currently receiving the dental care that you need?

No
Yes

M18. ***(If "No")*** Would you like help getting dental care?

No
Yes

Interviewer Summary Comment – Medical

Financial and Legal:

Interviewer: *The next set of questions is about financial or legal problems that night get in the way of your recovery.*

F1. Do you have money or legal issues that might make it hard for you to achieve your recovery goals? *(Check all that apply.)*

No		Insufficient income	
Criminal history		No income	
Bankruptcy		Owing too much money	
Alimony/child support		No health insurance	

Immigration status		Discrimination	
Other (specify)		Paying for medicine	
Other description:			

F2. Do you think you need help from a lawyer or other advocate with any of the following might make it easier for you to meet your recovery goals?

No	Alimony/child support
Criminal history	Immigration status
Bankruptcy	Insufficient income
Owing too much money	No income
No health insurance	
Discrimination	
Paying for medicine	
Other Specify	

F3. Do you need help getting:

Food stamps/WIC services		Clothing	
Delivered meals (for shut-ins)		Personal care items	
other (specify)			
Other description:			

F4. Are there other money or legal problems that might get in the way of your recovery?

No
Yes (Specify)

Interviewer Summary Comment:

Family Status and Parenting:

Interviewer: *We're most of the way done. I'm going to ask you about your family status and related matters.*

P1. Which of the following statements best describes where you are personally?

Single – no dependent children		Divorced – dependent children	
Single – dependent children		Committed relationship, but not married – no dependent children	
Married – no dependent children		Committed relationship, but not married – dependent children	

Married – dependent children		Widowed – no dependent children	
Divorced – no dependent children		Widowed – dependent children	

P2. Are you responsible for parenting children who live with you?

No
Yes

P3. Do you have children who have been taken from you by the courts (child welfare)?

No
Yes

Interviewer: *This item does not refer to custody issues stemming from a divorce settlement.*

P4. Are you concerned that your child/children could be taken by child welfare?

P5. Would you like help getting your life back together so that you can regain or keep custody of your children?

No
Yes

P6. Would child care services help you reach your recovery goals?

P7. Would you like help with any of the following:

P8. Would you like to receive family counseling?

No
Yes

Interview Summary Comment: - Family Status and Parenting

Recovery Wrap Up:

Interviewer:
There are three questions left. We ask you these questions to make sure that we have covered everything and to make sure we understand what is important to you.

W1. Can you think of anything we haven't already talked about that could hold you back from reaching your recovery goals?

No		Having to attend groups	
Scheduling difficulties		Having to take medications	
Other (specify)		Having to take drug tests	
Other Description:			

W2. Of everything we've discussed today, are there one or two things that you think are most important to achieving your recovery goals?

No		Spiritual support	
Treatment		Mental health services	
Housing		Medical services	
Employment		Family counseling/Therapy	
Recovering Peers		Benefits	
Other (specify)		Transportation	
Other description:			

W3. Is there anything we have not mentioned so far that would make it easier for you to reach your recovery goals?

No
Yes (Specify)

Interviewer Summary Comment – Recovery Wrap Up

Interviewer: *Thank you for taking the time to speak with me today.*

Lifetime Questions

Drug/Alcohol

	Years in Lifetime	Route of Administration
1. Alcohol - any use at all		
2. Alcohol - to intoxication		
3. Heroin		
4. Methadone		
5. Other opiates/analgesics		
6. Barbiturates		
7. Other sedatives/hyp./tranq.		
8. Cocaine		
9. Amphetamines		
10. Cannabis		
11. Hallucinogens		
12. Inhalants		
13. More than 1 substance per day		

How many times have you:

14. Had alcohol DT's?
15. How many times in your life have you been treated for alcohol abuse?
16. How many of these were detox only (alcohol)?
17. How much money did you spend during the past 30 days on alcohol? $ .00
18. How many times in your life have you been treated for drug abuse?
19. How many of these were detox only (drugs)?
20. How much money did you spend during the past 30 days on drugs? $ .00

Psychiatric

1. Have you ever been diagnosed with a mental health or emotional disorder by a doctor or mental health professional — Yes

How many times have you been treated for any psychological or emotional problems:

2. In a hospital?
3. As an outpatient or private patient?

Question Hints

Past 30 days: Any alcohol use at all, includes beer, wine, and liquor. Enter the number of days, not the number of times in the past thirty days. Recommended probe: Approximately how much do you drink each day?

Comments

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Access To Recovery

Understanding My Choices as an ATR Client

_____ _____

(Individual's Name) (Individual's Address)

Arkansas' ATR project is based on the following principles:

- Individuals with substance use disorders and their families have the right to choose recovery and the recovery-related services and supports that best meet their needs.
- The service system should honor clients needs and beliefs, including their spiritual and cultural needs as well as their family situation and practical concerns
- Participation in AR ATR is voluntary and clients can end their participation at any time, without negative consequences.

As an ATR client, we want to make sure that you understand your rights and the choices that are available to you. Your care coordinator should explain these rights to you. Please initial the lines below to indicate that you understand these rights.

____I understand that participation in Arkansas Access to Recovery is voluntary.

____ I understand that every community has at least 2 care coordinators and I get to choose who my care coordinator will be. I can also change my choice of care coordinators at any time.

____I understand that I get to choose the treatment and recovery support services that I need for me and my family.

____ I understand that I get to choose who provides the treatment and recovery support services that I need. I understand that I may change providers and services as my needs change.

I have ___ or have not ___ been informed of the services which are available to me in my community through the ATR Program and I understand my options.

I have been given the attached list of ATR Certified Care Coordinators and Service Providers for _____ county. From that list, I am choosing:

_____ to provide my Care Coordination Services and

(Fill in name of the chosen Care Coordination person/agency)

_____ to provide my treatment and recovery services.

(Fill in name of chosen treatment and recovery services provider(s)

This decision does ____ does not _____ represent a change in provider(s).

_____ _____

Client Signature Date

If you would like to change your care coordinator, please contact Peggy Miller by email at ppmiller@uams.edu or at 501-682-9900. To change providers or choices of treatment, please contact your care coordinator.